Case Management Treatment Plan for Active TB Disease

The purpose of this form is to provide a checklist to organize the gathering of information in a TB case to ensure the best medical and public health practices. Corresponding TB forms, both required and recommended, are listed with each component. (* denotes forms that are required by the state of Montana)

Patient Name _____ Date _____

___ Patient's contact information – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*

___ Assignment of responsibilities – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. TB Contact Investigation Report*
4. DOT – Treatment Record
5. TB Diagnostic Referral Form

___ Patient educator's name & dates of education – 1. Monthly TB Patient Assessment
2. Treatment of Active TB Education Form

___ Method for prevention of transmission – 1. Home Isolation Agreement

___ Planned course of antituberculosis drug therapy – 1. Confirmed/Suspected Report of TB Disease*
DOT plan
2.TB Case Monthly Report*
3. DOT - Treatment Record
4. DOT Agreement

___ Estimated date of completion of treatment - 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. DOT - Treatment Record

___ Test results from initial medical evaluation – 1. Confirmed/Suspected Report of TB Disease*

___ Medical history – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. Monthly TB Patient Assessment

___ Diagnosis – 1. Confirmed/Suspected Report of TB Disease*
2. TB Diagnostic Referral Form
3. Bacteriology Data Sheet

___ Baseline tests, monitoring of activities, – 1. Confirmed/Suspected Report of TB Disease*
Drug therapy & side effects 2. TB Case Monthly Report*
3. Monthly TB Patient Assessment
4. DOT – Treatment Record
5. DOT – Adverse Reactions & Side Effects
6. Bacteriology Data Sheet
7. Biochemistry Data Sheet

___ Potential drug interactions - 1. TB Case Monthly Report*
2. Monthly TB Patient Assessment
3. DOT – Treatment Record
4. DOT – Adverse Reactions & Side Effects

___ Potential treatment adherence obstacles – 1. TB Case Monthly Report*
2. Monthly TB Patient Assessment
3. DOT – Treatment Record
4. TB Home Evaluation
5. Treatment Active TB Education Form

___ Personal service needs & social services referrals – 1. Monthly TB Patient Assessment
2. TB Home Evaluation

___ Referrals for social services - 1. Monthly TB Patient Assessment
2. TB Home Evaluation

___ Ensuring completion of treatment – 1. DOT – Agreement
Incentives, enablers, adherence 2. DOT – Treatment Record
3. Monthly TB Patient Assessment
4. Treatment of Active TB Education Form

___ Intermediate & expected outcomes – 1. TB Case Monthly Report*
Sputum & culture conversion 2. Monthly TB Patient Assessment
Symptom improvement 3. DOT Agreement

TB DISEASE MONTHLY PATIENT ASSESSMENT

Name: _____ DOB: _____ Date of Visit: _____ Interpreter: _____
Location of visit: Home___ Office ___ Other _____
Case conference last done on: _____
Type of TB: Pulm. TB Y / N **Date Of Last CXR: _____**
Extra-pulm. TB Y / N Site:_____ **Improved: _____**
Currently infectious Y / N **Stable: _____ Worse: _____**

Other Medical Conditions

None
Asthma Cancer
COPD Diabetes
ESRD GI
Hep C / Hep B HTN
Liver Pregnant
Other:_____

Tobacco use Y / N
Cessation Counseling Y / N

Medications / Changes

Anti-coagulants
Anti-hypertensives
Coumadin
HIV meds
Immunosupressives
Insulin
Oral Hypo-glycemics

Other: _____

Education

DX, Infection Vs. Disease_____
Transmission/Prevention_____
Meds: Resistance/Side Effects_____
General health care_____
HIV/AIDS information
Counseling & testing_____
TB & HIV_____
Diagnostic Procedures_____
Community Resources_____
Other:_____

Assessment

Weight:_____ B/P: _____
Pulse Oximetry :_____% LMP: _____

AFB:
Sputum ____ Urine ____ Other _____
Last date submitted: _____
Due:_____
Containers given for (date):_____
Problems: _____

Lab work drawn:
HFP
CMP Y / N
CBC Y / N
Other: _____ _____ _____

Vision check:
Distance: Rt._____ L._____
Both:_____ Glasses: Y / N
Color vision all plates seen: Y / N
Problems:_____

Hearing screening: Y / N Results:_____

Balance: WNL ABN

Reactions to Meds

Hepatotoxicity INH,RIF, EMB, PZA
Jaundice Y /N
Fever Y / N
Nausea Y / N
Light stools Y / N
Vomiting Y / N
Dark urine Y / N
Abd. Y/N

Hypersensitivity INH,RIF, EMB, PZA
Rash Y / N
Arthralgia Y / N

Non specific INH,RIF, EMB, PZA
Headache Y / N
Malaise Y / N
Fatigue Y / N
Anorexia Y / N

Neurotoxicity INH, EMB
Paresthesia Y / N
Dizziness Y / N
Visual changes Y / N
Distance Y / N

Hemolytic RIF
Bruising increase Y / N
Bleeding gums Y / N
Hematuria Y / N
Hematochezia Y / N

Psychosocial

Alcohol / Drug use_____
Behavioral / Mental Health _____
Homeless _____
Language barrier _____
Cultural barrier _____
Limited cognitive skills _____
Transportation _____
Long work hours _____
No insurance _____
Inadequate food/income _____
_____

DOT
Missed doses in past month _____
Problems:
_____
_____
_____
_____

Referrals:
_____
_____
_____
_____

Nurses' Comments:
_____
_____
_____
_____

Re-interviewed for more **contacts** Y / N Comments:_____
PHN Signature:_____ Date:_____

MONTHLY TUBERCULOSIS CASE REPORT

Submit 1st day of every month- *new information from last report only*

Today's Date:_____

Department of Public Health & Human Services
TB Program
Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Submitted By: _____

Agency: _____

Phone:_____

This Report is being submitted for: Month _____ Year _____

Patient Name: _____

City: _____ County: _____

Diagnostic Update:

Sputum Conversion: Collect until 3 consecutive negative results

Test	Date Collected	Result	Test	Date Collected	Result
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		

X-Ray: Date: _____ Result: _____

HIV: Date: _____ Result: _____

Other Tests: _____ Date:_____ Result: _____

Most Recent Medical Exam: Date:_____ Result: _____

Symptoms: ( ) Cough ( ) Productive cough ( ) Fever ( ) Night Sweats
( ) Chest Pain ( ) Weight Loss ( ) Other, specify: _____

Hospitalization: Date: _____ Admitting Diagnosis: _____

Medication - Treatment and Adherence:

DOT Plan (describe) _____

Self-Administration: _____

Breaks in Therapy: (give specific date, doses, reason)_____

List medication side effects:_____

Medication	Dose	Date Started	Projected Length of Therapy	Date Treatment Completed	Date Meds Dc'd and reason e.g. side effects, resistance, moved
Isoniazid -INH					
Rifampin - RIF					
Pyrazinamide - PZA					
Ethambutol - EMB					
Other:					

Therapy Completed & Case Closed: _____ (This will be the final report)

LTBI MONTHLY PATIENT ASSESSMENT

(LATENT TB INFECTION)

Name:_____ DOB:_____ Date of Visit:_____ Interpreter: _____
Location of visit: Home___ Office ___ Other _____
Case conference last done on:_____

Other Medical Conditions

None
Asthma Cancer
COPD Diabetes
ESRD GI
Hep C / Hep B HTN
Liver Pregnant
Other:_____

Tobacco use Y / N
Cessation Counseling Y / N

Medications / Changes

Anti-coagulants
Anti-hypertensives
HIV meds
Immunosupressives
Insulin
Oral Hypo-glycemics

Other: _____

Education

DX, Infection Vs. Disease_____
Meds: Resistance/Side Effects_____
General health care_____
HIV/AIDS information
Counseling & testing_____
TB & HIV_____
Diagnostic Procedures_____
Community Resources_____
Other:_____

Assessment

Weight:_____ B/P: _____

Pulse Oximetry :_____% LMP: _____

Other: _____

Chest X-ray: date _____

Lab work drawn:

HFP
CMP Y / N
CBC Y / N
Other: _____

Reactions to Meds

Hepatotoxicity INH, RIF, EMB, PZA
Icterus Y /N
Fever Y / N
Nausea Y / N
Light stools Y / N
Vomiting Y / N
Dark urine Y / N
Abd. Y/N
Hypersensitivity INH,RIF,EMB,PZA
Rash Y / N
Arthralgia Y / N
Non specific INH, RIF, EMB, PZA
Headache Y / N
Malaise Y / N
Fatigue Y / N
Anorexia Y / N
Neurotoxicity INH , EMB
Paresthesia Y / N
Dizziness Y / N
Visual changes Y / N
Distance Y / N
Hemolytic RIF
Bruising increase Y / N
Bleeding gums Y / N
Hematuria Y / N
Hematochezia Y / N

Psychosocial

Alcohol / Drug use_____
Behavioral / Mental Health_____
Homeless_____
Language barrier_____
Cultural barrier_____
Limited cognitive skills_____
Transportation_____
Long work hours_____
No insurance_____
Inadequate food/income_____

DOT

Missed doses in past month _____
Problems:

Referrals:

Nurses' Comments:

PHN Signature:_____ Date:_____

TB Case Management Monitoring Record (4/2003 sample)

Case name:_____ DOB_____ Rec #_____

LHD or PMD_____Phone_____ Fax _____

Diagnostic Evaluation: Symptoms *(circle all)* *Date cough started:* _____

Cough, **S**putum: thick/thin, color:_____, **H**emoptysis, **F**ever, **N**ight **S**weats, **M**alaise, **W**t.**L**oss of ____lbs

Diagnostic Microbiology:

	Date of spec	Type of spec	AFB smear	AFB culture	Susceptibilities
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

TST: Date:_____ _____MM o Not done

CXR[6]: _____

TREATMENT PLAN: o 6 MONTH o OTHER: _____

Pt. Wt. =

(# months of treatment-→ NOTE: regimen & total # of doses determins when completes treatment)

	Start Month	1st month	2nd month[5]	3rd month	4th month	5th month	6th month	7th month	8th month	9th month
INH _____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
RIF _____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
PZA _____mg	_____	_____	____ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _
EMB _____mg	_____	_____	_____ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _
B6 _____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
# DOT doses:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

(Initial phase doses . . . . . / Continuation phase doses [pt should receive all initial phase doses first])

Self Administered (Standard of care is to be on DOT: only extremely rare circumstances would justify self administered)

 # doses injested/mo _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

MONTHLY MONITOR:

Side effects[1]	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Isolation[2] Yes/ n/a	_____	_____	_____	____ _ _	_ _ _ _ _	……	……	……..	……	…….
Smear status[3]	above	_____	_____	____ _ _	_ _ _ _ _	……	……	……..	……	…….
Culture status[4]	above	_____	_____	_____ _	_ _ _ _ _	……	……	……..	……	…….
Clinical Resp [5]	_____	_____	_____	____ _ _	_ _ _ _ _	……	……	……..	……	…….

Chest X-ray[6] . . . . . .3mo prn_____ . . .End of tx_____

MD/clinical Evaluation _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

[1] Side effects: ∅ = none noted, **P** = problem: see progress notes (symptom review, labs as ordered, visual/color while on EMB)

[2] Sputum smear positive cases should be isolated until non-infectiousness is established by: demonstrate a good clinical response to treatment, AND have been on adequate TB treatment for 2 weeks, AND have 3 consecutively negative sputum smears for AFB.

[3] Pulmonary cases: collect at least one monthly to document conversion to negative smear, then collect 2nd & 3rd to document non-infectiousness and release from isolation. Frequency of collection depends on severity of illness and diagnostic sputum smears.

[4] Pulmonary cases: collect one monthly to document conversion to negative cultures

[5] Clinical response: list letter code for persistent symptoms (eg/ **C** for cough), improved, or resolved. AFTER 2nd mo., eval the regimen.

[6] Initial: **C**=cavitary, **N**on-**C**avitary:infiltrates, scaring, nodules, etc ./ prn=improved, stable, worse / End= improved, stable, worse

PAGE_____

Client Name: _____**DOB**_____**Address:**_____**Phone:**_____**I.D.**_____

Clinical Path - Dx.: Positive PPD Physician: _____

KEY

D = Demonstrates X = Done
U = Understands I = Instruct/Reinstruct
C = Complies VR = Variance
0 = None N/A = Not Applicable
N/C=No Change / = Did Not Assess

OUTCOMES/GOALS:	DATE MET:	Signature	Initials
Client or caregiver will understand disease process and screening procedures			
Client or caregiver will verbalize understanding of significant occurrences and when to call health care provider			
Client or caregiver will follow-up with recommended medical care within ( ) days of nursing visit			
Client or caregiver will verbalize understanding of possible complications if follow-up not obtained			
Client or caregiver will leave with all questions relating to condition answered			
Client or caregiver will verbalize understanding of importance of finishing treatment			

Date					Nurse's Evaluation and Progress Notes
DIRECT CARE Initials					
Assess vital signs □ BP					
□ Pulse					
□ Respirations					
□ Temperature					
Allergies:					
Screening tests completed/Results:					
□PPD results _____mm Date:_____					
□Chest x-ray					
□Liver function					
□Visual Acuity					
□Sputum culture/gram stain/sensitivity					
Assess risk factors:					
□Medical conditions, including HIV					
□Living arrangements/Low income					
□Contact with people with active TB					
□Immigrants					
□Illicit drug use					
□Elderly or child < 4 years					
□Occupational exposure					
Assess relevant psych/social dimensions:					
□Insurance/income to cover screening & treatment					
□Able/willing to comply with treatment					
Assess for s/ s of medication side effects:					
□Loss of appetite					
□Dark colored urine					
□Jaundice					
□Rash/itching					
□Blurred vision					

Medication side effects (cont): Date					Nurses' Evaluation and Progress Notes
Unusual pain in hands/feet/joints					
Headache					
Dizziness/Drowsiness					
Nausea/Vomiting					
Convulsions					
General tiredness					
Assess for s/s of active TB:					
Cough					
Hemoptysis					
Chest pain					
Fatigue/malaise					
Weight loss					
Fever/night sweats					
INSTRUCTION AND INFORMATION					
Prevention recommendations:					
Finish medications					
Testing contacts					
Vitamin B6					
Future PPD/x-rays					
Educational materials discussed and given:					
S/s of active TB					
Medication sheets					
Signs and symptoms of complications					
Active vs latent TB					
Referrals made to:					
Physician					
HIV testing					
Follow-up appointment kept with/date:					
Medications (list) and DOT (as applicable):					
Confidentiality of Records per protocol					
Informed Consent per protocol					
Next PHN visit or follow-up call					

Tuberculosis Treatment Record
Directly Observed Therapy - DOT

Patient Name: ____

Public Health Nurse: ____

Agency: ____

Physician: ____

Pharmacy: ____

Prescription: ____

____

Date	Place of Visit	Prescribed Medications Oral meds/Dosage					*Adverse Reactions	Client Incentives	PHN Signature
		INH	RIF	PZA	EMB				

*** Adverse reactions = record on Monthly Assessment Form & consult with MD ASAP**

Tuberculosis (TB)
Directly Observed Therapy Agreement

To: _____ **D.O.B.:_____**
Patient name

Because it is very important that you follow the doctor's orders so that you are cured of TB, you are being placed in a supervised treatment program by your physician and the County Health Department.

This program requires that you:

Take your TB medicine while being observed by the Public Health Nurse or other designated staff as indicated below (days, time, and location):

LOCATION: _____
DAYS: **Monday Tuesday Wednesday Thursday Friday** (circle 2 days if bi-weekly)
TIME: _____a.m. / p.m.

We want to help you get better as quickly as possible and to protect those around you from getting TB. If you do not follow these directions for treatment, your condition could worsen and you could spread the disease to others. If you do not continue supervised treatment, the County may pursue legal action against you, which if convicted, may result in court ordered detainment for your treatment.

_____ _____
PHN or Designee Signature Date

I have read the above information, understand it, and agree to the conditions.

_____ _____
Patient's Signature Date

_____ _____
Interpreter Signature *(if needed)* Date

Copy given to patient _____ (PHN or Designee Initials)

DIRECTLY OBSERVED THERAPY RECORD

Name of Patient: ______________________________ **Isolation Residence:** ______________________________________

Date	Time	Medication Given		Comments (List any other meds given, and/or if contact was attempted and patient wasn't home)	Staff Signature
		Θ Isoniazid Θ Pyrazinamide Θ Pyrixodine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
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		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
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		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		